

## ATTACHMENT "D"

### INTENSIVE IN-HOME FAMILY SERVICES

#### **The North Dakota Model**

In the last three bienniums providers of Intensive In-Home Family Services were asked to use the North Dakota model of service provision. This model allows services to be developed to fit the family's needs rather than trying to fit the family into the service. We would propose that this model continue to be used in the future.

The evolution of family-based programs nationwide has witnessed a gradual reduction, overall, in length of service to families. Although this may be a national trend, in a state with contrasting urban/rural needs, this will require building more flexibility into the way Intensive In-Home Services are provided. We will need to attend to the different service approaches required with such clients as Native Americans, military families and other minorities. Moving toward one model that will ascribe services to fit the needs of the family is congruent with meeting the needs of clients where they are and keeping the length of service brief, solution-focused and outcome-based.

### **PROPOSED ASSESSMENT COMPONENTS**

Assessment for family-based services would, as before, begin with dialogue between the family and the referring agency. The referral to Intensive In-Home Services would begin a collaborative assessment process that integrates subject information and objective data through formal assessment instruments. The collaborative group would consist of family members, the family-based service therapist, and the referring agency/case manager. Goals of the assessment process would include:

1. Identification, negotiation and prioritization of risk factors and treatment needs;
2. Development of an outcome-based treatment plan which is behaviorally specific, with proposed time frames; and
3. Provision of treatment, including referral to community resources as dictated by the treatment plan.

The intensity and duration of services would be determined by the collaborative group.

The professional literature identifies a number of factors important to the assessment of risk and needs in families. These factors should include **assessment of risk early into services, availability of concrete or hard services, family strengths, and the family members' mental capacity to participate.**

Other factors are the child's needs, including physical, cognitive, social and emotional; family structure, characteristics of past maltreatment (child and adult), and parent/child interaction.

These factors are an important part of the assessment. To address these factors as a part of the assessment, formal assessment instruments will need to be utilized.

The vendor would choose from a menu of assessment tools to assist the family and collaborative team in determining the family's service needs. Information from collateral sources would also be considered, which is congruent with the overall eco-structural approach to evaluating the family's needs.

It is hoped that the proposed assessment process will facilitate a more thorough assessment in a shorter time, the development of more specific goals based on objective and subjective information, and the opportunity to consistently measure outcomes besides prevention of placement. Examples of assessment tools are sited below.

\* (1) Stephen Magura, Beth Silverman Moses, Mary Ann Jones, "Assessing Risk and Measuring Change in Families, The Family Risk Scale," (Child Welfare League of America, 1987)

\* (2) Stephen Magura, Beth Silverman Moses, "Outcome Measures for Child Welfare Services, Child Well-Being Scales and Rating Forms", (Child Welfare League of America, Inc., 1987)

\* (3) Stephen J. Bavolek, Ph.D., AAPI, "Adult-Adolescent Parenting Inventory," (Family Development Resources, Inc., 1984)

## TREATMENT PLANNING

The North Dakota model of Intensive In-Home Services would move the treatment planning to goals being more behavioral while remaining systemic. In order to maximize the brief therapeutic experience, **a more specific assessment with treatment plan-driven time frames and intensity would empower the family to move rapidly towards independence of the social service network.** Brief solution-focused therapy utilizing short- and long-term goals with measurable increments teaches skills and allows the family to practice new techniques, and have success or failure. Outcome-based goals could be more concrete and clear to the family in terms of their own change process. The family would then be in a better position to communicate with collaterals, demonstrate their improved ability, and perhaps manage more pro-actively the next crisis.

It will become a part of the collaborative effort to prioritize which goals to address in treatment. The proposed assessment and treatment plan model would allow the provider to predict future issues so that returning to services may be planned rather than seen as the family's failure.

When goals are developed that are specific, measurable, and achievable, the chance for success becomes much greater. The provider and the family would then move to more long-range goals that would be achieved within the time frame allowed. This would give the family a sense of accomplishment and success within the "window of opportunity" afforded by the crisis.

## LENGTH OF SERVICE

At the completion of assessment (5 to 30 days out), the collaborative team mentioned earlier would meet. This team would be made up of appropriate family members, the Intensive In-Home therapist, the referring case manager and any other referring agency people invited by the family. This meeting should include the sharing of the completed assessment with an outline of a proposed treatment plan. This group should jointly review the materials, discuss a proposed plan, make negotiated revisions, and attach time frames and frequency of sessions to each goal. It is at this point that the parties involved enter into a therapeutic contract for the duration of the Intensive In-Home treatment. For some referrals, it could mean no more than 30 to 45 days of service (much like the current Homebuilders model). The majority of families should be able to complete their work with the Intensive In-Home program in 3 to 4 months. Some cases may need more time, and we would propose a time limit of 6 months, with the understanding that such length would be justified. The frequency of sessions toward the end of the 6 months would taper off, allowing the family to practice what they have learned.

During the collaborative meeting, the Intensive In-Home therapist would take a position of mediation. If there were differing opinions regarding treatment goals or length of service, the therapist could mediate this process. The referring case manager would be the determiner of issues such as length of service, and the family would ultimately be in

charge of determining what treatment goals they will work toward and with what intensity they can work. In North Dakota there are vast differences between counties and geographic regions of the state. Some counties provide many follow-up services within their own agency and do not need Intensive In-Home Services to intervene for more than intense crisis cases. Whereas, some smaller counties do not have the resources to follow therapeutic goals with clients, nor are there out-patient services accessible. The length of service will vary given the differences between counties and geographic regions of the state.

## **IMPLEMENTATION OF THE NORTH DAKOTA MODEL OF INTENSIVE IN-HOME**

The intensity and length of service for a particular family will dictate the therapists' availability for new cases and total caseload. Currently in the Iowa model, therapists typically carry 6 cases. In Homebuilders, the range is from 2 to 4 cases, depending on the families' willingness to meet on a more frequent basis. Implementing this model will mean more internal managing of caseloads. The treatment plans will be very specific as to the frequency of service, so the duration of the service should be quite predictable.

## **SUMMARY**

In summary, the North Dakota model should 1)provide an enhanced assessment process leading to more 2)outcome-based treatment plans that would include 3)timelines and frequency limits for each case. The benefits would be a service that is more congruent with the needs of specific families.

(FOOTNOTE: The North Dakota model of Intensive In-Home Services as described was written with the assistance of Sandi Christofferson, MSW, LICSW.)